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The
Surgeon General's Letter
on

CHILD SEXUAL ABUSE

C. Everett Koop, MD, ScD
Surgeon General of the U.S. Public Health Service

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Maternal and Child Health and Resources Development
Office of Maternal and Child Health

DEPARTMENT OF HEALTH & HUMAN SERVICES

The Surgeon General of the
Public Health Service
Washington DC 20201

Dear Colleague:

Every year about a million children are physically maltreated and abused. Over 110,000 of these children are sexually abused. The physical and mental health consequences to these children are simply overwhelming.

Federal and state laws make child abuse, including child sexual abuse, a crime. But to be truly effective, these laws require the informed cooperation and close collaboration of health, social service, law enforcement, and criminal justice professionals.

Many health professionals -- physicians and nurse practitioners, nurses, hospital social workers, and others -- are already dealing with the problem of child sexual abuse. Others would like to, but they are still unclear about the role and responsibilities of health professionals in these matters. Hence, the purpose of this Surgeon General's Letter is to help health professionals properly identify and treat a child who has been sexually abused, make the required report to the right state agency, respond to the needs of the child's family, and cooperate with social service and law enforcement personnel at each step. This Letter is not the "last word," but rather it's an introduction and guide for health professionals who want to know more about this new and growing issue in public health and want to know what they should do, when a victim of child sexual abuse appears in their office or institution.

This Letter is intended primarily for the use of primary care physicians, nurses, nurse practitioners, and other health professionals who encounter sexually abused children only occasionally in their practices. Those who work in Child Sexual Abuse Centers have their own protocols to follow.

The Office of the Surgeon General developed this Letter with support from the Children's Bureau of the Department of Health and Human Services, the Office for Victims of Crime of the U.S. Department of Justice, and several agencies of the U.S. Public Health Service. Overall guidance was supplied by a very able Planning Committee, listed in the Appendix. Many public and private service agencies throughout the country also helped by contributing copies of their child sexual abuse protocols and other materials for study.

I hope this Letter helps you and the children in your care.

Sincerely,

C. Everett Koop, MD, ScD
Surgeon General

Organization of The Surgeon General's Letter on Child Sexual Abuse

This Letter is divided into five Sections:

Section I offers a *working definition* of the term "child sexual abuse."

Section II discusses the filing of the *report,* as required by law.

Section III concerns the *history* taken from a child victim, the first step in the assessment process.

Section IV describes the *physical examination* to be done, the second step in the assessment process.

Section V highlights the differences between the *civil and criminal court processes,* a major area of confusion for many health professionals.

Section I: The Definition

The following definition of "child sexual abuse" is based on the language in the federal statute. The same kind of language is also found in state child abuse laws:

- *Child sexual abuse* occurs if a child – any person under the age of 18 – is made to engage in, or to help someone else engage in, any sexually explicit conduct, such as intercourse, sodomy, the fondling of genitals, and oral copulation.

- It also occurs if the child is molested or raped, is involved in incest, or is sexually exploited, as in child prostitution or pornography.

- A child is abused if he or she is enticed, bribed, threatened, or coerced in some way, particularly by force, to engage in any of these acts, or if the child is developmentally not old enough or mature enough to understand the consequences or implications of these acts.

Most child sexual abuse cases are *intra*-familial (i.e., they occur within the family), but a fair number are *extra*-familial, involving persons outside the family unit. Hence, the abuser can be a parent,

family friend, older sister, younger brother, baby-sitter, teacher, coach, or any other relative of the child or any stranger of any age or either sex. In fact, the great majority of children are abused by someone they know and often trust. Child sexual abuse also occurs among all segments of society; it is a public health issue that crosses all economic, social, racial, and ethnic boundaries.

While this definition reflects the language of the law, each health professional -- whether a physician, nurse practitioner, nurse, hospital social worker, or any other -- should consult with law enforcement personnel to learn of any special provisions in the laws of his or her state.

Section II. The Report

While rape is included in definitions of sexual abuse, it is also a major crime by itself. Hence, if a child is brought in and says that he or she has just been raped (or the person who brought the child says so), you should immediately contact the police, who will assess the situation and take charge of the case. Such reporting, of course, is the responsibility of any citizen with information about *any* major crime.

A case of child sexual abuse may be a concern of many different agencies in the community: child protective services, family services, law enforcement, civil justice (juvenile and family court), and criminal justice, as well as health care. Many cases of child sexual abuse may eventually involve all these agencies or systems. However complicated these cases may become, they usually begin quite simply when someone files a brief *Report,* usually by telephone, to child protective services and/or the police.

Every state and territory requires all health professionals to report to state authorities "any knowledge of" or even "any suspicion of" child abuse and neglect, including child sexual abuse. Many states specify the categories of health personnel who must report (e.g., nurses, dentists, osteopaths, interns, etc.); others merely say "any person" must report. State laws may also impose a penalty on anyone who has such knowledge or suspicion but does *not* report it.

You would "have knowledge of" child sexual abuse, for example, if a parent or a social worker brings in a child for medical attention and tells you that the child was -- or may have been -- sexually abused. That's when you "know" that sexual abuse of the child is, at the very least, a possibility, and that's what you must report. But what does "suspicion" mean? In child sexual abuse, as in virtually every other

area of patient care, a professional person's own instinct, honed by experience day in and day out, gives rise to those "suspicions" that are the basis of good clinical judgment. And such judgment is the first line of defense for every child who is abused.

Here are some circumstances in which you should "suspect" child sexual abuse:

* A parent brings in a child who shows signs of physical injury in the genital area and is experiencing pain. When asked about these symptoms, the child offers a history which is not consistent with your own clinical findings (was rough-housing with friends, fell off playground equipment, etc.). But the clinical information *and your own "gut feelings"* tell you otherwise: you suspect that the child may have been sexually abused. You must, therefore, report your suspicion to the child protective services agency.

You don't know who may have sexually abused the child and you don't know where or when the abuse occurred. But as a health professional, you don't *have* to know. If, in your own best clinical judgment, you suspect the child has been abused, then you must report that suspicion to your local or state child protective services agency.

* A caseworker brings in a child who shows no outward signs of injury or abuse, but is presented as "always not feeling quite right." The child is reticent and even sullen, avoids eye contact with both you and the parent, and cannot -- or will not -- tell you what or where the trouble is. As you begin a routine physical exam, the child becomes fearful and highly stressed. When you begin to examine the genital and anal areas, the child becomes violent and tries to break free. (Some child victims may do just the opposite: flop back in a highly suggestive position of total surrender.)

You may not know who abused the child, but it's not your responsibility to find out. If you suspect that the child is or has been the victim of sexual abuse and needs protection, that's reason enough for you to make a report. And, by law, you must.

* A child shows up for his or her annual physical examination. In the course of your workup, you discover the child has a sexually transmitted disease, vaginitis or urinary tract symptoms, or other signs and symptoms that raise serious suspicions of possible sexual abuse. Again, you are obliged to report your suspicions to the local or state child protective services agency.

But what if you're wrong? What if, in any one of these cases, the child had not been abused and, therefore, your suspicions cannot be substantiated?

All state laws recognize this concern and provide immunity for anyone who reports in good faith. A health professional who reports a suspected case of child sexual abuse that is later shown *not to have occurred*, is protected by a "cloak of immunity" from any civil or criminal liability that might arise because of the report and subsequent events.

The reverse, however, is *not* true. For example, a health professional who doesn't report a suspected case of child abuse that actually *did* occur, has no "cloak of immunity" and can be sued for malpractice by the victim's family or prosecuted by the state for failing to report. A number of such cases have indeed been brought -- and won -- against health professionals in the last few years. Clearly the wisest and safest choice is to obey the law and report.

But when should you make your report? How? And to whom?

Most laws and guidelines advise you to report "in a timely fashion." That usually means immediately or, at the very least, within 24 hours. If a child is brought in by someone who alleges that the child was sexually abused within the past few hours, you must report that information right away. If, during a physical examination for another problem altogether, you come across scarring or other physical findings of sexual abuse sometime in the past, you should report *that* information "in a timely fashion," also.

An initial report is usually made by telephone. Most states also require a written follow-up report within 36 hours. Whether or not you file a written report with the state, make a note for your own records of *what* you said, *to whom* you said it, and *when*. As a general rule, a person who files a prompt written report with as much detail as possible is less likely to be asked to testify in civil court later on; the written report will generally speak for itself. (However, you may still be required to appear in a criminal proceeding; for more on this, see Section V.)

All reports should be made directly to the child protective services of your own state. Some state offices have you call a "hot-line" or an 800- number; others have you report to a local or regional representative. Here again, it's important to know the specific requirements of the law in your own state.

Should you call the police, also? Where state law requires dual and crossreporting, then of course you should call the police, too. However, in most jurisdictions, that decision is most often made by personnel in child protective services. But if the child -- or you or anyone involved with the child -- is in some immediate danger, or if

the child has been raped or sodomized, then the police should be called right away.

At some time early in the process, you must tell the child's parent or guardian that you either know or suspect that the child has been sexually abused and, under state law, you are required to report such knowledge or suspicion to the state office for child protective services. It is important to say this in as calm and dispassionate a manner as possible, indicating to the parent that you must take this action since sexual abuse could explain one or more symptoms presented by the child. If you are on the staff of a health facility, you may also wish to cite its policy or guideline in such matters. Virtually every hospital or clinic in the country does have a protocol or a policy requiring its personnel to report any knowledge or suspicion of child sexual abuse to the child protective services agency. But whether or not there is such a policy, reporting is *by law a personal responsibility* that cannot be transferred to an institution.

Most public systems and processes are haunted by the possibility that, instead of receiving service, a person needing help will somehow "fall through the cracks." To prevent this, it is advisable to "cross-report" cases of child sexual abuse, when appropriate. For example, if a child is brought to you by a police officer, note that fact and the officer's badge number and precinct. After making your initial report to child protective services, make a second call to the precinct desk and confirm the information there, also. It's far better to file a redundant report than to risk having the child "lost" by any system of protection and care.

Similarly, it's important to avoid making, or seeming to make, any accusations of guilt in your report. The person who brought you the child may be the abuser...or may be one of several abusers...or may be nothing of the kind. That determination, however, is the province of law enforcement and the courts.

Section III. Assessment: The History

The assessment of a child victim of sexual abuse consists of the taking of a history, followed by a physical examination. Interviewing a child who has been sexually abused, however, is not the kind of history-taking that has been taught in most schools for the health professions.

The prime objective is still, of course, to elicit enough information to make a diagnosis and determine a course of treatment. But there are other objectives as well: the information gathered during the patient

assessment will help the state take the most appropriate civil action to protect the child from further abuse; it may help the state initiate criminal action against the perpetrator of the abuse; and it can provide clues for social service personnel helping the child's family get through a period of time suffused with pain, anger, fear, frustration, or guilt.

While clearly important for your purposes of providing effective health care for the child, your initial encounter may also be the child's first indication that an adult is concerned about what happened and wants to help. Hence, during the interview some children will want to share a great deal of information about their family's social, legal, or other problems. From a health point of view, these are of marginal interest; if you pursue them, you risk contaminating the data in your assessment and substantially limiting its usefulness. In this respect as in all others, it is therefore essential that you maintain as your *primary* concern the physical and mental health of the child.

If the interview is conducted soon after the abuse occurred, the child's recollection will be at its clearest, and the interviewer will be most alert to important signs and signals from the child. Carefully record verbatim any statements the child may make about the (alleged) abuser, since these statements are admissible in court. Some experts urge that this initial interview be videotaped, arguing that such a videotape eliminates the need for re-interviews, which only compound the anguish of the child and the family. But videotaping is generally used far less by health professionals than by court, police, and protective services personnel, who frequently enter their videotaped interviews into court proceedings.

No single approach works best with every child. Each assessment differs according to a child's developmental age and his or her place within the family. Also, some sexually abused children may be too young to be interviewed or too disturbed to give a coherent medical history. In those instances, the answers must instead come from the child's parent or guardian (assuming this person is not, in fact, the suspected abuser).

It is sometimes advisable for health professionals to have someone present from child protective services and, if possible, law enforcement present during the interview. This is especially helpful if you suspect that the child being interviewed was sexually abused in a group setting, such as a pre-school or day care center, raising the possibility that other children are still at risk. Dealing with such a possibility is a task for persons other than health professionals.

The following pointers on conducting an interview, while generally applicable, are particularly useful with children age three and above who may have been sexually abused:

o Make sure the child is comfortable. If you show impatience and other signs of not caring, you may be identified in the child's mind with the abuser...and the assessment will go badly.

o If it appears possible that a family member may be the perpetrator of the abuse, insist on interviewing the child alone; send parents and other family members into another room to wait. Later, they can verify certain minimum items of fact (e.g., the child's full name, address, home telephone number, age, year in school, etc.). You may also note any statements they might make relative to the physical and mental health of the child.

o Even though you may know -- or strongly suspect -- that the child has been sexually abused, you should take great care to restrict your questions exclusively to the realm of the physical and mental health of the child. Also, as in your initial report, be sure that you don't influence the interview so that it merely reinforces your own judgment as to whether or not the child was sexually abused. That determination will be made elsewhere through due process.

o Note the child's use of any sexually provocative mannerisms directed toward you. This kind of learned behavior is often presented by very young sexually abused children. Note also the child's tone of voice and, to the extent possible, write down *verbatim* any especially revealing remarks by the child.

o If you use anatomically correct dolls or line drawings, ask the child to name different body parts, with specific attention to the breasts, genitals, and buttocks. Abusers frequently teach their young victims special names for these body parts; the names then become "their secret." These visual aids can also help a child explain what happened. But here, also, you must be very careful not to "lead" the child to focus on particular body parts and functions.

o Ask the child about his or her physical, emotional, and mental health. But remember that each possible symptom of abuse is, by itself, of limited significance. This is precisely where good clinical judgment is so important. You must ask yourself: Is this or that symptom truly out of the ordinary, given this particular child, at this age, in this family, in this particular state of health?

Ask about such symptoms as...

trouble urinating (dysuria)...blood in the urine (hematuria)... involuntary urination, especially as bed-wetting (enuresis)...and any

pain, fever, discharge, or itching that may be related to urinary tract infections or genital lesions.

abdominal pain...anorectal problems, such as itching, bleeding, and pain...fecal incontinence (encopresis)...and other evidence of bowel habit dysfunction.

excessive masturbation...indications of sexual knowledge unusual or inappropriate for a child that age...and sexual experience generally, including knowledge of -- and experience with -- oral, rectal, and/or vaginal penetration during prior abusive incidents.

any rash or sores in the genital area...herpes or other sexually transmitted disease...and, for female patients, vaginal odor, pain, itching, bleeding, or unusual discharges.

and, for adolescent patients in particular, ask about the frequency and severity of headaches...dramatic weight changes...trouble sleeping, including nightmares and other disturbances...serious problems in school...the abuse of drugs and alcohol...depression ...thoughts of -- or attempts at -- suicide...phobias of one kind or another...use of birth control devices and medication...and pregnancy.

If the interview is not going well, don't force it by asking leading questions; stop and get assistance from child protection or local law enforcement personnel with more experience in these cases. Do not let your own eagerness, curiosity, sense of outrage, or any other personal feelings influence you to continue the interview along lines that lie outside your own professional competence.

After the history has been taken, go on to the physical examination of the child.

Section IV. Assessment: The Physical Examination

Every child who is or may have been a victim of sexual abuse must be given a physical examination. If the most recent incident -- known or suspected -- occurred within the past 72 hours, or if the child is in pain or shows clear evidence of injury, you should examine the child immediately. (If the child has just been raped, however, you should contact the police right away and obtain a commercial rape kit for the examination. Take great care in following the directions that are enclosed with the kit.) If speed is *not* of the essence, the child may then be examined by you at the earliest convenient time or referred elsewhere for that service.

If you feel you may lack sufficient skill or experience to do a physical examination of a child for signs of sexual abuse, you may want to refer that child to a facility or a team with the requisite skills to handle the assignment, if one is locally available. In any case, take a moment now to become familiar with local referral procedures; you might not have the time to do so later, when a potential child victim is in your office and in need of immediate help.

Both the child and the parents or caretakers should be told about -- and prepared for -- such an exam. All necessary permissions should be secured and the parents briefed on the kinds of lab tests that may be done, the purpose of each (screening, diagnostic, forensic), when the results will be available, and who will see them. This is also the time to alert parents to any financial assistance for which they might qualify, such as victim's compensation or other funds that cover medical and/or legal expenses.

The physical exam should be done in the presence of someone the child can trust...a parent (if not the abuser) or a familiar nurse. Quietly explain what's going to happen and note the child's reaction.

If the child was sexually abused within the past few hours, begin the exam, if possible, by passing a Woods Lamp over the child's body and clothing. Seminal fluid shows up as a fluorescent dark green under a Woods Lamp. Obtain a specimen and have it checked for motile and non-motile sperm and for acid phosphatase. A Woods Lamp, however, is not always accurate; hence, it's also important to collect the child's clothing in a paper bag for a more accurate examination by the police lab.

Many sexually abused children are also victims of other forms of physical abuse and neglect. Therefore, while a physical exam for signs of sexual abuse will necessarily center upon the urogenital and anorectal areas, it should be done as part of a complete physical exam. For example, suspicious marks might be detected on the child's legs, breasts, and buttocks during a quick overall physical; such marks are often caused by blows or restraints used during episodes of sexual abuse and they should be noted.

Take special care to prepare the child for your examination of the anal and genital areas. A toddler may prefer to be examined while in its mother's lap; young children are most comfortable in the frog-leg position; older girls, however, should be examined in the customary lithotomy position. Gently spread the labia majora laterally and down, with some pressure against the perineum. This allows you to inspect each part of the genitalia (prepuce, labia minora, etc.). A magnifying colposcope is sometimes used to obtain a more precise assessment of external trauma. If you suspect the presence of

internal vaginal injuries, the examination may need to be done with the child under anesthesia.

The most frequent signs of sexual abuse in the genital area of a female include bruises and lacerations; unusual redness of skin and tissue (erythema); bleeding and evidence of intradermal or submucosal hemorrhaging (the presence of petechiae); unusual changes in skin color or pigmentation; unusual discharges and odors; and scarring in the region of the posterior fourchette. Scars of former injuries are especially important, since they indicate that the sexual abuse might be a chronic problem, heightening the possibility of further danger to that child. In addition, note the child's Tanner Stage of genital and breast development, the condition of anal tone, and the condition of the hymen, its shape, and its precise horizontal diameter.

Both male and female children may present scarring or injuries in the rectal and perianal areas, also. Injuries would include lesions, furrowing, creases, discoloration, and poor anal tone. A magnifying colposcope is useful here, also. Any relaxation of the sphincter or excess dilatation of the anus -- signs often difficult to diagnose -- may also indicate sexual abuse, especially in conjunction with other signs or with the particular history you've taken.

The child may cooperate in such a personally sensitive physical examination, or may object and not remain still. *Under no circumstances should the child be restrained or in any way coerced into continuing with the examination.* If you cannot proceed together, then stop and note for the record what has happened, writing down the child's objections *verbatim,* if possible.

Be as thorough as you can, but -- again -- as a *health professional* and *not* as a judge and jury. For example, if you identify certain bruised tissues, describe *what and where* those injuries are. Don't speculate that the bruising was "caused by the father" or was a "result of sexual abuse." *How* the bruising occurred will be determined by others later.

An "instant" camera, such as a Polaroid Land Camera loaded with color film and used with flash, may also be helpful during the physical examination. Although any kind of camera can be used, many courts seem to favor pictures from an "instant" camera rather than the more common slides or prints. An "instant" camera can provide an immediate and permanent (generally tamper-proof) record of bruised and reddened tissues long after they've returned to their normal color.

Be aware, however, that a child may become uneasy and even excitable at the presence of a camera, particularly if he or she has

been photographed by an abuser during sexually explicit or humiliating behavior. Also, older children become embarrassed and will object to having pictures taken of their genital and rectal areas. In these cases, make a record of the child's response and put the camera away.

Laboratory tests can be key elements in the chain of evidence of child sexual abuse. You need the results to make a proper diagnosis and plan of care; the state needs the results to determine the best way to protect the child, treat the family, and take action against the abuser. Your local police or prosecutor's office can provide you with guidelines for the correct handling and labeling of test specimens and results. A final word of caution: Before ordering any test, consider the physical and emotional condition of the child. If a test will cause further trauma for the child, it would be best to postpone or even cancel it, noting very clearly in the record your reasons for doing so.

The following tests are most often used in cases involving child sexual abuse:

* If fewer than 72 hours have elapsed since the abuse took place, test for the presence of *sperm, acid phosphatase, and blood group antigens.* The presence of sperm or seminal fluid is a key piece of evidence in court. Isolate any *hairs* that may be present, especially foreign pubic hairs. Take samples of the child's *saliva and hair,* as controls.

* For female adolescent victims, many experts also recommend a *urine pregnancy test,* to be repeated at an appropriate interval.

* It is advisable to request the following tests, also, to determine the presence of any *sexually transmitted diseases:*

A McCoy cell culture of the rectum and the penile urethra (for males), the vaginal vestibule (for prepubertal females), or the cervix (for post-menarcheal females) should be ordered to detect the presence of *chlamydia.* Currently available *non-* culture tests for chlamydia are not satisfactory for use in cases of suspected abuse.

Cultures for *Neisseria gonorrhoeae* on a selective medium should be obtained from the throat, urethra, rectum, and vagina and/or cervix, if appropriate. The presence of gonorrheal vulvovaginitis in a prepubertal child or a positive *gonorrhea* culture from the rectum or throat of a child of *any* age is strong evidence of sexual abuse. But keep in mind that other microorganisms are often *mis*-identified as *N. gonorrhoeae;* therefore, a definitive identification should be made in a laboratory using sensitive and specific biochemical identification tests.

* If AIDS and syphilis are prevalent in your area, then tests should be requested to detect the presence of these diseases as well:

The serologic test for *syphilis* (a V.D.R.L. or R.P.R.) should be performed at the time of the initial examination; if appropriate, this test should be repeated 6 to 12 weeks later.

Schedule blood tests for the presence of *AIDS* (HIV) antibodies, starting with a repeatedly reactive enzyme immunoassay (EIA), followed by a Western blot or a similar, more specific assay. The test should be done immediately, if chronic abuse is indicated, or from 6 to 12 weeks after an acute assault. (NOTE: In acute cases, if testing for AIDS antibodies is done *before 6 weeks* have passed, the probability of a false negative is very high; but if it's done *after 12 weeks* have passed, the probability of a false negative *or* positive is as low as 1 percent.)

Finally, use a rape kit if you can determine that there was penetration or ejaculation by the abuser, that the sexual abuse occurred within the past 72 hours, or that the child has not yet bathed. A rape kit enables the average health professional to treat a victim of sexual abuse, yet collect evidence for possible criminal investigation and prosecution. Commercial rape kits are available from supply houses serving law enforcement crime labs; they cost about $10-$15 each and are used only once.

The data gathered during the assessment process -- that is, during the history-taking (the interview) and the physical examination -- form the basis for subsequent decisions affecting the child victim, the child's family, and the person or persons responsible for the abuse. In the interests of both health and justice, the data must be complete, accurate, and objective.

Section V. Civil and Criminal Proceedings

The Constitution and the laws of the United States provide equal protection for every person's life, liberty, and well-being. This protection extends to children, who can't protect themselves from sexual abuse and other dangers. This protection may include civil protective and custody proceedings, as well as criminal prosecution of the abuser. Medical evidence, gathered initially by health professionals, can be crucial to both the civil and criminal determinations.

If, in the course of its investigation, the child protective services agency suspects that a parent has been sexually abusing a child, the

agency may petition the juvenile or family court for permission to take certain actions to protect that child. The court may give the agency permission to take those actions, including the removal of the child from the family, if necessary. The court may then appoint a guardian *ad litem,* an attorney who would represent the child in court; the parents would then be represented by their own and different attorney.

The petition may ask that the abusing parent leave the home and that another member of that household be responsible for the child's welfare. Or it may ask the court to remove the child from the home and seek placement in protective custody with relatives or in a foster care setting. However, removing children from their own home is a big step. The courts hesitate to approve such a step unless there is a preponderance of evidence that the child was indeed sexually abused at home and is likely to be abused there again. Part of that evidence, of course, would be the assessment of the health professional who saw the child.

Very often the real or imagined charge of sexual abuse of a child is enough to bring about the dissolution of a troubled marriage. In such cases, a second civil (divorce) court may be involved. If that occurs, one parent may petition the juvenile/family court for custody of the child and the limitation or denial of visitation rights for the other parent. The civil courts may then have *two* petitions to consider: one from the child protective services agency and one from the parent.

Generally, that's what occurs on the civil side. On the criminal side, however, the police may become convinced that a child has indeed been sexually abused by, say, one parent. They would then take their information to the district attorney, citing all the evidence, including your assessment of the child's physical and mental health. If the evidence is persuasive, the district attorney would then file criminal charges against the alleged abuser. In communities that employ a multidisciplinary approach, the public prosecutor may consult with several professionals representing difierent agencies and disciplines (including health) who then arrive at a joint decision on the best way to proceed with the case.

At that point the child may be involved in *three* different cases: a criminal case against the abusive parent, a civil action by child protective services to shield the child from further harm, and a second civil action, a divorce case, in which one parent requests custody of the child and denial of visitation rights for the other.

Meanwhile, as the responsible health professional who filed the initial report and examined the child, you may be involved in one, two, or all three proceedings. Your willingness to appear is as important to the health and welfare of the child as your initial

history and physical exam are. But the chances are also good that no such request will be made and that you will hear nothing at all about the case or cases. Safeguards for investigations and for personal privacy virtually seal off all information until a trial is held or a final ruling of the court is made public. However, the safest attitude is to be prepared to testify in any case and to cooperate fully with counsel.

The system seeks to be fair to all, yet render protection and justice to children. It is, therefore, a complicated system. For health professionals, generally unfamiliar with the world of civil and criminal law, it may be bewildering and even intimidating. Nevertheless, in each instance the victimized children, caught in the vortex of these actions, require the best possible service from all professionals, whether in law enforcement, the courts, social services, or health care. Helping you provide that care, immediately when needed, is the purpose of this Letter.

Appendix

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The following persons contributed to this publication as members of the Surgeon General's Planning Committee:

Richard L. Cage, Detective Lieutenant, Montgomery County Police, Rockville, Maryland

Robert E. Cramer, Jr., District Attorney, Huntsville, Alabama

David E. Grossman, Judge, Hamilton County Juvenile Court, Cincinnati, Ohio

Dorothy V. Harris, ACSW, Past President, National Association of Social Workers, Silver Spring, Maryland

Leah Harrison, RN, MSN, CPNP, Assistant Director of Child Protective Services Program, Montefiore Medical Center, Bronx, New York

Richard Krugman, MD, Director, C. Henry Kempe National Child Abuse and Neglect Center, Denver, Colorado

Jean E. Matusinka, Superior Court Judge (Criminal Division), Los Angeles, California

Clare Marie Rodgers, RN, MSN, CPNP, Past Secretary, National Association of Pediatric Nurses and Practitioners, Annapolis, Maryland

Robert W. ten Bensel, MD, MPH, Professor of Public Health and Pediatrics, University of Minnesota School of Public Health, Minneapolis, Minnesota

Joyce N. Thomas, RN, MPH, President, Center for Child Protection and Family Support, Washington, D.C.

The Planning Committee was assisted by the following people in the federal government:

Jane N. Burnley, PhD, Director, Office for Victims of Crime, U.S. Department of Justice, Washington, D.C.

Theodore O. Cron, Special Assistant to the Assistant Secretary for Health and the Surgeon General, Washington, D.C.

Juanita C. Evans, Division of Maternal and Child Health, USPHS, Rockville, Maryland

Helen Howerton, former Director, National Center for Child Abuse and Neglect, Washington, D.C.

William Modzeleski, Director, National Victims Initiative, Office for Victims of Crime, USDJ, Washington, D.C.

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Maternal and Child Health and Resources Development
Office of Maternal and Child Health
5600 Fishers Lane
Rockville, Maryland 20857

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